San Francisco Department of Public Health

Guidance

Interim Guidance: Prevention and Management of COVID-19 in Long-Term Care Facilities

Last updated May 5, 2022

The following guidance was developed by the San Francisco Department of Public Health (SFDPH) for use by local facilities and will be posted at http://www.sfcdcp.org/residentialcareproviders.

Summary of Changes since the 3/24/2022 Version

- Updated isolation and quarantine guidelines for SNF residents to align with CDC interim infection prevention and control for skilled nursing facilities.
- Updated isolation and quarantine guidelines for RCF residents to align with SF modification of CDPH 4/6/22 guidance for RCF residents who are less than up-to-date and close contacts.
- Updated exposure risk assessment and work restriction for asymptomatic HCP with SARS-CoV-2 exposures or close contact.
- Updated definition of "close contact" to align with CDPH[3]

AUDIENCE: Administrators of Long-Term Care Facilities (LTC Facilities; LTCFs), which encompass the California Department of Social Services/Community Care Licensing Division and Department of Public Health Licensing and Certification Program Facilities in San Francisco. These include Adult Residential Facilities (ARF); Residential Care Facilities for the Elderly (RCFE); Residential Care Facilities – Continuing Care; Social Rehabilitation Facilities; Residential Care Facilities for the Chronically Ill (RCFCI); and Skilled Nursing Facilities (SNF) that provide 24-hour skilled care on-site.

PURPOSE: To help LTCFs understand the health practice and safety requirements at their facility to prevent and manage the spread of COVID-19 among staff and residents. This interim guidance may change as knowledge, community transmission, access to vaccines, community practices, and state guidance change. Updated State and local Health Orders, and CDSS guidance will supersede this document. Facilities are responsible for following updates by CDPH or CDSS in a timely manner and for updating Mitigation Plans required by their licensing bodies.

BACKGROUND: LTC Facilities provide residential care to people who require varying levels of support. Because of the heterogeneity of residents, facilities, access to and uptake of prevention, treatment, and vaccination strategies, SFDPH is summarizing key components of infection prevention and mitigation of transmission, which will closely follow CDPH and CDSS guidance.

This document provides a summary guidance to LTC Facilities in the City & County of San Francisco on:

Positive case: reporting, isolation, and quarantine

Reporting

Reporting a suspected or confirmed COVID-19 case or outbreak[1] is required under AFL 20-75. **Isolation** refers to separation of a positive or suspected case from others. **Quarantine** refers to the observation period after last high-risk exposure[2] or close contact[3]. and varies with each facility's proportion of staff and residents who are up-to-date and with individual vaccination status and risk factors for severe disease.

All facilities are required to notify SFDPH when a suspected or confirmed COVID-19 case is identified:

SFDPH COVID-19 Disease Response Unit (CDRU)
Contact: COVID.Outbreak@sfdph.org or (415) 554-2830

Notify SFDPH CDRU promptly if:

- Suspected or lab-confirmed positive SARS-CoV-2 test in residents or staff, or
- Three or more residents or staff with new-onset respiratory symptoms within 72 hours of each other, or
- Residents with severe respiratory infection resulting in hospitalization or death.

Initiate the following steps when a resident or staff case is identified:

1. **Isolate positive or symptomatic individual(s)**; see Zoning section and AFL 20-74; for RCFs, see PIN 21-12-ASC. Please note that although it is not a State or local mandate for residents to be up-to-date on vaccination[4] (instead of fully vaccinated), it is highly recommended in order to provide the strongest health protections for residents in these settings.
2. Identify and **quarantine close contact residents** in accordance with CDC and CDPH guidance adjusted for RCF residents who are not yet up-to-date with vaccinations.*
3. **Notify** SFDPH CDRU per Reporting section above.

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[1]An outbreak in a LTCF is one or more facility acquired COVID-19 cases in a resident. Thresholds for additional investigation and mandatory reporting to the health department are noted in AFL 20-75.
2A high-risk exposure is an exposure to aerosol generating procedures in a known COVID-19 individual without full PPE.
3A close contact is an individual who shared air space with a COVID-19 infected person for > 15 mins in a 24-hour period.
4 Per San Francisco H.O. C19-07y, "Up-to-Date on Vaccination" means when a person both (i) is Vaccinated with a Complete Initial Series and (ii) has received a Booster once the person is Booster-Eligible. A person is Up-to-Date on Vaccination immediately on receipt of a Booster. Until a person is Booster-Eligible, they are considered Up-to-Date on Vaccination two weeks after completing their full initial series of vaccination.

4. **Test** close contacts[3]. Initiate testing response (see Testing section) as indicated.
5. **Cohort residents** according to symptoms, vaccination status, and testing results, as outlined in CDC, PIN 22-09-ASC, and PIN 21-49-ASC. **Cohort staff** and plan for ongoing staffing needs: Keep all staff assigned to work only with positive ("red" area) or exposed/symptomatic/screening ("yellow" area) or negative/recovered ("green" area) residents during that shift (See Zoning section).
6. **Outbreak status, admissions** during surges: see AFL 21-08 and AFL 20-87 on crisis and contingency planning for staffing shortages and collaborating with SFDPH to resume admissions during outbreaks.
7. **Communicate** with SFDPH as requested during the outbreak.
8. **Monitor positive and exposed residents** with the frequency described below. **Notify their physician as soon as possible.**

Isolation and Quarantine

Directives can be found at https://sfdph.org/directives. For LTC facility staff and residents, use Table below. For questions, contact COVID.Outbreak@sfdph.org.

LTC Facility isolation and quarantine table for **asymptomatic** individuals:

<table>
<tr><th>Facility type</th><th>Who</th><th>Guidance</th><th>Vax status</th><th>ISOLATION</th><th colspan="2">QUARANTINE/work restriction</th></tr>
<tr><td rowspan="4">SNF</td><td rowspan="2">Staff</td><td rowspan="2">AFL 21-08</td><td>UTD</td><td>5 days with negative test, mask 10d (or 10d no test)</td><td colspan="2">None; test and mask as per AFL 21-08</td></tr>
<tr><td>Not UTD</td><td>7 days with negative test, mask 10d (or 10d no test)</td><td colspan="2">7 days with neg testing <48h prior to exiting quarantine, mask 10d (or 10d without test)</td></tr>
<tr><td rowspan="2">Resident</td><td rowspan="2">CDC</td><td>UTD</td><td rowspan="2">10 days and no fever and improving if not immune-compromised. If immune-compromised, 10-20 days with clinical consultation</td><td>Facility >90% UTD

None; test and mask per CDC guidance</td><td>Facility <90% UTD

7d with neg testing <48h prior to exiting quarantine if no symptoms, mask 10d (or 10d wo test)</td></tr>
<tr><td>Not UTD</td><td colspan="2">7 days with neg testing <48h prior to exiting quarantine if asymptomatic, mask 10d (or 10d without test)</td></tr>
<tr><td>RCF</td><td>Staff</td><td>PIN 22-09-ASC</td><td>UTD</td><td>5 days, negative test, mask 10</td><td colspan="2">None; test and mask per PIN 22-09-ASC</td></tr>
</table>

				days OR 10 days no test	
			Not UTD	7 days, negative test mask 10d (or 10d no test)	7 days with neg testing <48h prior to exiting quarantine if asx, need mask 10d (or 10d wo test)
	Resident	CDPH I&Q guidance 4/6/22*	UTD*	5 days, negative test, mask 10d OR 10 d no test	None; mask 10 days, test at recommended interval
		CDPH I&Q guidance 4/6/22*	Not UTD*		5 days with neg testing; mask 10 days OR 10 days without testing

*SF DPH uses up-to-date for RCF residents referring to 4/6/22 CDPH I&Q guidance, Table 1 and 3, rather than fully-vaccinated, so RCF residents who are not yet up-to-date and close contacts must quarantine as above.

Resident considerations: isolation of residents who test positive

Per the CDC, SNF residents who test positive and are symptomatic should be isolated (**regardless of their vaccination status**) until the following conditions are met:

- At least 10 days have passed since symptom onset; AND
- At least 24 hours have passed since resolution of fever without the use of fever-reducing medications; AND
- Any other symptoms have improved
- **See CDC for more guidance regarding individuals who are severely immunocompromised** (e.g., currently receiving chemotherapy, or recent organ transplant), or who had critical illness (e.g., required intensive care).

For RCF-Es, facilities should follow 4/6/22 state I&Q guidance per chart above, so RCF residents who test positive and are asymptomatic should isolate for at least 5 days with testing.

Residents who test positive and are asymptomatic throughout their infection should be isolated for at least 10 days following the date of their positive test. Everyone who tests positive should wear a well-fitted mask for 10 days, regardless of vaccination status or isolation.

Resident considerations: observation or quarantine of residents

Refer to the CDC and PIN 21-49-ASC for guidance on: **new resident admissions or re-admissions**; **symptomatic residents** regardless of vaccination status; and **asymptomatic residents who are not up-to-date on vaccinations and close contacts** of positive individuals.

- Per the CDC, SNFs that are able to contact trace and have ≥90 percent staff and residents up-to-date on vaccination may allow residents who are up-to-date on vaccination to monitor symptoms but not quarantine after close contact. This does not apply to SNFs with less than 90 percent staff and residents up-to-date on vaccination, or those unable to contact trace.

Guidance on removing residents from isolation or quarantine

Facilities should refer to the LTC facility Isolation and Quarantine Table above for most residents, as well as the CDC for residents who may need longer quarantine. When additional clinical input is needed or if residents have worsening symptoms, facilities should consult their infection preventionists and medical providers, and if needed, SFDPH.

Additional clinical input is recommended for symptomatic residents who test negative for COVID-19 and other viral infections. They should remain in quarantine unless clinical consultation determines another cause for symptoms, with appropriate treatment per the CDC.

Please refer to CDC guidance on removing positive individuals from isolation to determine isolation.

Resident outings (leaving and returning to the facility)

NOTE: As noted above, although the AFLs below refer to "fully vaccinated" residents and HCP **and there is not a State or local mandate for the standard of up-to-date on vaccination (instead of fully vaccinated) is highly recommended for residents in order to provide the strongest health protections.** HCP are required by CDPH to be up-to-date on vaccination.

- SNF residents who are up-to-date on vaccination and leave the facility do not need to quarantine upon return if they have not had known close contact with a positive individual during their outing, per AFL 22-07.
- SNF residents who are not up-to-date on vaccinations—or who live in a facility where <90% of all staff and residents are up-to-date—and have a close contact outside the facility should test upon return and quarantine and test at day 5, to leave by day 7 or remain in quarantine for 10 days.
- Regardless of vaccination status, asymptomatic close contact residents should be tested as soon as possible and at 5-7 days after exposure. If someone becomes symptomatic after close contact, they should start to quarantine and test immediately; see Symptomatic Testing below.
- Unvaccinated and incompletely vaccinated residents who leave the facility for < 24 hours and return to the facility should be tested at 2 days after their return and again 5-7 days after their return. Unvaccinated and incompletely vaccinated residents who leave the facility for > 24 hours should be quarantined in the yellow-observation area for the recommended interval and tested prior to return to their usual room in green-unexposed/recovered area.
- RCF residents may go back to their original area even if >24-hour outing, if they did not have a close contact while away from the facility, per PIN 21-49-ASC.

Health care personnel (HCP) and staff considerations: isolation and quarantine (work restriction)

Exposure Risk Assessment for HCP

Hospitals should and SNFs must use the CDC's updated risk assessment framework to determine exposure risk for HCP with potential exposure to patients, residents, visitors, and other HCP with confirmed COVID-19 in a health care setting. CDC's updated definition of higher-risk exposure includes use of a facemask by HCP (instead of a respirator) while caring for an infected patient who is not also wearing a facemask or cloth mask. CDC guidance for assessing travel and community-related exposures should continue to be applied to HCP with potential exposures outside of work (e.g., household,) and among HCP exposed to each other while working in non-patient care areas (e.g., administrative offices). For the purpose of contact tracing to identify exposed HCP, the exposure period for the source case begins from two days before the onset of symptoms or, if asymptomatic, two days before test specimen collection for the individual with confirmed COVID-19.

Figure 1 below outlines work restriction (isolation and quarantine) guidelines for HCP, per AFL 21-08. RCFs should follow PIN 22-09-ASC.

- Any HCP or Staff with a newly positive COVID-19 test, diagnosis of COVID-19, or COVID-19 **symptoms** must isolate, regardless of vaccination status, according to AFL 21-08 and **PIN 22-09-ASC**.
    - HCP whose most recent test is positive and are working before meeting routine return-to-work criteria must maintain separation from other HCP as much as possible (for example, use a separate breakroom and restroom) and wear a N95 respirator for source control at all times while in the facility.
    - Similarly, exposed unvaccinated and vaccinated HCP who are booster-eligible but have not yet received their booster dose who are working during their quarantine period should also wear a N95 respirator for source control at all times while in the facility until they meet routine return-to-work criteria.
    - In addition, healthcare facilities should make N95 respirators available to any HCP who wishes to wear one when not otherwise required for the care of patients or residents with suspected or confirmed COVID-19.
    - Asymptomatic positive HCP should not care for residents who have not tested COVID-19 positive until at least 10 days from the date of the HCP's positive test.
    - Positive HCP who meet criteria to work should use a fit-tested N95, self-monitor symptoms for 10 days, and must stop working if they become symptomatic.
    - Refer to CDC guidance for more information on HCP with severe to critical illness or who are moderately to severely immunocompromised.
- **For HCP or staff with a close contact or high-risk exposure, follow PIN 22-09-ASC. and AFL 21-08.**
    - Facilities may consider more restrictive measures to prevent the spread of COVID when community case rates are moderate or high, such as testing staff who are up-to-date on vaccination who had a close community contact (see CDC guidance).
    - All HCP and staff must monitor and mask for 10 days. If symptoms develop, individuals must test and follow guidance immediately, as outlined in **AFL 21-08** and **PIN 22-09-ASC.**
- Additional clinical input is recommended for symptomatic staff who test negative for COVID-19 and other viral infections; they should not work if symptomatic and consider repeat testing with clinician input.

Figure 1: **HCP work restriction (isolation and quarantine) guidance tables, from** AFL 21-08. Similar tables are available for RCFs in PIN 22-09-ASC.

Work Restrictions for HCP with SARS-CoV-2 Infection (Isolation)

Vaccination Status	Routine	Critical Staffing Shortage
Boosted, OR Vaccinated but not booster-eligible	5 days* with negative diagnostic test† same day or within 24 hours prior to return OR 10 days without a viral test	<5 days with most recent diagnostic test† result to prioritize staff placement‡
Unvaccinated, OR Those that are vaccinated and booster-eligible but have not yet received their booster dose	7 days* with negative diagnostic test† same day or within 24 hours prior to return OR 10 days without a viral test	5 days with most recent diagnostic test† result to prioritize staff placement‡

Work Restrictions for Asymptomatic HCP with Exposures (Quarantine)

Vaccination Status	Routine	Critical Staffing Shortage
Boosted, OR Vaccinated but not booster-eligible	No work restriction with negative diagnostic test† upon identification and at 5-7 days	No work restriction with diagnostic test† upon identification and at 5-7 days
Unvaccinated§, OR Those that are vaccinated and booster-eligible but have not yet received their booster dose§	7 days with diagnostic test† upon identification and negative diagnostic test† within 48 hours prior to return	No work restriction with diagnostic test† upon identification and at 5-7 days

*Asymptomatic or mildly symptomatic with improving symptoms, and meeting negative test criteria; facilities should refer to CDC guidance for HCP with severe to critical illness or moderately to severely immunocompromised.

† Either an antigen test or nucleic acid amplification test (NAAT) can be used. Some people may be beyond the period of expected infectiousness but remain NAAT positive for an extended period. Antigen tests typically have a more rapid turnaround time but are often less sensitive than NAAT. Antigen testing is preferred for discontinuation of isolation and return-to-work for SARS-CoV-2 infected HCP and for HCP who have recovered from SARS-CoV-2 infection in the prior 90 days; NAAT is also acceptable if done and negative within 48 hours of return.

‡ If most recent test is positive, then HCP should provide direct care only for patients/residents with confirmed SARS-CoV-2 infection, preferably in a cohort setting. This may not apply for staff types or in settings where practically infeasible (e.g., Emergency Departments where patient COVID status is unknown) or where doing so would disrupt safe nurse to patient ratios, and for staff who do not have direct patient/resident care roles.

§ In general, asymptomatic HCP who have recovered from SARS-CoV-2 infection in the prior 90 days do not require work restriction following a higher-risk exposure.

Testing guidance

State guidance is rapidly changing in response to case rates, vaccination status, and CDC recommendations. For testing guidance, please refer to the CDC, PIN 22-10-ASC, PIN 20-23-ASC. Any updates to the Health Orders, AFLs and PINs will supersede this guidance.

Symptomatic testing

Regardless of vaccination status or prior positive test, **all** residents and/or staff who are **symptomatic** need to test immediately. Test results depend on how much virus is in the sample at the time of the test so **consider retesting in 2 days and clinical consultation,** especially if antigen test results are negative but symptoms persist.

Diagnostic screening testing

For asymptomatic residents and/or staff without close contact or high-risk exposure to a positive case. In all instances, LTC Facility resident/staff that are asymptomatic and **previously tested positive within the last 90 days, should not undergo surveillance testing unless symptomatic.**

Residents:

- Per the CDC, SNF residents who are not up to date with vaccinations need to test on admission unless tested 72 hours prior to admission, quarantine, and test again before exiting quarantine.
- SNFs should consider periodic (for example, weekly) diagnostic screening testing for residents who are not up-to-date and regularly leave the SNF for dialysis or other regular medical visits; in the absence of suspected or confirmed COVID-19 transmission at the dialysis center, residents who leave the facility for dialysis do not need to be quarantined in a "yellow" area.
- All new RCF residents should be tested prior to moving into a facility per PIN 21-17.2-ASC.

HCPs/staff:

- HCP who are unvaccinated or not up-to-date on vaccinations in SNFs:
    - HCP who are unvaccinated or have not received their booster but are booster-eligible must undergo **at least twice weekly** SARS-CoV-2 diagnostic screening testing. **Certain staff may require different cadence of testing, refer to** AFL 21-34**,** AFL 21-28 and AFL 21-29**.**
- HCP with up-to-date vaccination in SNFs:
    - Diagnostic screening testing of asymptomatic employees with up-to-date vaccination is not required.
    - Facilities may consider diagnostic screening testing in individuals with underlying immunocompromising conditions (e.g., organ transplantation, cancer treatment), which might impact the level of protection provided by COVID-19 vaccine.
- RCFs should consult the **supplemental guidance to PIN 22-05.1-ASC** for testing and placement guidelines for staff based on their vaccination status. **PIN 21-32-ASC** provides additional information on staff and resident testing.

Response testing

Updated CDC guidance continues to recommend immediate investigation as a potential outbreak when one (or more) COVID-19 positive individuals (resident or HCP) is identified in a facility.

- SNFs should refer to the CDC when applying response testing options in facilities that are able to contact trace AND have ≥90% HCP and >90% residents up-to-date on vaccination, including steps to take after close contact with a positive individual.
- Per PIN 22-07-ASC, independent living residents are only exempt from response testing if they do not receive assisted living services or use any of the communal facilities (e.g. dining, activities, transportation) at their facility.
- **See CDC Interim guidance for HCP** for guidance on **high-risk exposures in the community for HCP** (e.g., household contact, intimate partners.)

Vaccination and other infection prevention and control guidelines for COVID-19

Preventing transmission from the community and staff to residents is essential. Using mitigation tools, such as vaccination, screening, ventilation, personal protective equipment, cohorting, and testing is crucial for infection prevention and control.

Vaccination

Up-to-date vaccination prevents severe illness and death due to COVID-19. In San Francisco, **up-to-date vaccination is required for LTC Facilities workers and highly encouraged for all residents and visitors.** CDPH also recommends vaccination and booster doses for all eligible individuals in these settings (see AFL 22-09). For employees eligible for a booster, guidance is available here. The California Health Orders are summarized here.

Under San Francisco H.O. C19-07y, all booster-eligible health care workers must receive their booster by March 1, 2022. Those not yet eligible for boosters must comply no later than 15 days after the recommended timeframe for receiving the booster dose, or within 90 days of recovering from an acute COVID-19 infection.

The key requirements for LTC facilities are to:

- Ensure that all workers are up-to-date on vaccination or have submitted an approved exemption
- Ascertain vaccination status of all personnel who work onsite; refer to **San Francisco H.O. C19-07y**, State **health orders**, **AFL 21-28**, and **PIN 22-05-ASC** for approved vaccination documentation
- RCFs should consult the **supplemental guidance to PIN 22-05.1-ASC** for testing and placement guidelines for staff based on their vaccination status.
- Require any exempt less-than-up-to-date or unvaccinated staff to:
    - Test for COVID-19 at least **twice** weekly in long-term care settings OR follow a specific cadence for high-risk congregate settings (see AFL 21-28 and AFL 21-29) **AND**
    - Wear a well-fitted surgical mask or higher-level respirator at **all** times except while actively eating or drinking; **AND**
    - Provide a declination form to the LTC Facility with appropriate documentation for qualifying medical or religious exemptions.
- The facility must:
    - Provide all exempt, not up-to-date on vaccination staff a well-fitted non-vented N95 in settings where residents have access or care is provided and/or an FDA-cleared surgical masks in any setting that does not require a respirator.
    - Keep records of resident and employee vaccination status or exemption and provide these to health authorities within one business day of the request.

Screen and monitor everyone for symptoms

- All visitors, staff, vendors, residents returning from outings, and other individuals (except for 911 responders) should be screened for fever and COVID-19 symptoms upon entry, per AFL 22-

07 and PIN 22-07-ASC. Visitors should share contact information in case contact tracing is needed later.

- Always follow all recommended precautions to prevent COVID-19 regardless of screening, as even boosted staff, visitors, or residents may transmit asymptomatic infection.

Prevent staff from working while ill

COVID-19 infections often start from household or community-acquired illness among staff, who then transmit to others at facilities. Refer to PIN 22-09-ASC, AFL 21-08, CDC's Updated Healthcare Infection Prevention and Control in Response to COVID-19 Vaccination and CDC Return to Work criteria for healthcare personnel:

- Facility HR should be aware of resources for positive or symptomatic staff, e.g., isolation and quarantine, food, cleaning supplies.
- **Symptomatic staff, regardless of vaccination status, should notify their supervisor and NOT report to work.**

Recognize and respond rapidly to COVID-19 signs and symptoms in older adults

- Monitor all residents daily for fever T>100.4 and COVID-19 symptoms; residents in quarantine or observation should be monitored twice a day (or once a shift) and residents with confirmed or suspected COVID-19 infection should be monitored twice a shift or every 4 hours.
- People with COVID-19 can have no symptoms, subtle symptoms, or moderate to severe illness. Recognize **atypical symptoms of COVID-19 seen among older individuals**, because these can often predict worsening and hospitalization: **changes mental status (e.g., lethargy, confusion, agitation, or behavior change), poor oral intake, and/or falls or weakness.**

Ventilation

Viral transmission is primarily airborne and worse in poorly ventilated spaces. The **HIGHEST RISK** of transmission is **wherever masks are taken off indoors**, even among individuals who are up-to-date on vaccination. With lower risk of transmission outdoors, facilities should:

- Maximize fresh air circulation in the facility. Follow CDPH guidance and consider outdoor options whenever safety and security allow.
- Avoid overcrowding, even among individuals up-to-date on vaccination.
- Post visual cues prompting adequate ventilation. Breakroom signage can be found here.
- Consider placing portable air cleaners (HEPA or MERV13 air purifiers) in areas wherever masks are taken off indoors, especially break rooms or common areas with poor ventilation.
- Check with building maintenance or operations to avoid recirculating air and to identify the optimal filters that may be used in your HVAC system.

Personal protective equipment (PPE)

Provide specific training on transmission-based precautions and appropriate use of PPE.

- **Ensure that all staff have been fit-tested for N95 respirators**. When fit-testing staff, reinforce procedures to prevent the spread of infection and staff exposure/shortages. Fit-testing is valid for one year; skilled nursing facilities should **renew fit-testing annually.**

- Everyone should practice hand hygiene and wear properly fitting face coverings to enter the building. **Facilities must strictly adhere to CDPH Masking Guidance and continue to adhere to Cal/OSHAs standards for aerosol transmissible diseases and emergency temporary standards.**
- In addition, refer to SF Health Order C19-07y and CDPH Health Order December 22, 2021, as well as: PIN 21-38-ASC, PIN 20-23-ASC, AFL 20-74 (see chart) and CDC guidance.

Hand hygiene and disinfection

- Maintain hand hygiene for residents and staff, especially when entering the building, entering/exiting meal areas or break rooms, exiting bathrooms, and before/after communal activities. Ideally, soap and water are best for hand hygiene. Maintain running warm water, soap, and paper towels for handwashing; avoid hand-driers that blow air to avoid spreading aerosols.
- Clean all surfaces as per CDC guidance, as droplet transmission mitigates other concurrent respiratory infections.

Physical distancing

In general, maintaining 6 feet reduces overcrowding. Greater distances may be safer, depending on the aerosol-generating activity, rate of shedding of the individual, source control, ventilation, and susceptibility of others.

- Refer to PIN 21-17-ASC, PIN 22-07-ASC, and AFL 22-07 regarding distancing during visitation and among residents during dining and communal activities, which considers vaccination status.
- Reduce seating in common areas to avoid overcrowding, especially break rooms.

Special considerations for memory care and behavioral units

Prioritize Memory Care units and Behavioral units (locked units) for early, active measures to prevent infection which can lead to rapid transmission.

- Per PIN 21-19-ASC, consider opening windows for ventilation when feasible, safe, and secure or portable air cleaners per CDPH guidance on ventilation.
- To reduce risk of rapid transmission, use creative strategies to keep residents out of quarantine and isolation areas; games to remember handwashing; and other cues.
- For PPE with residents in Memory Care, refer to the CDC and PIN 21-19-ASC.

Visitation guidance may change depending on case rates, variants, and staffing; it is key to communicate with families about visitation updates.

Resident cohorting and zoning

Cohorting is a strategy for controlling transmission by grouping residents into specific zones or pods, treated by assigned HCPs. The ability to quarantine exposed and isolate suspected/confirmed individuals will vary by facility, and this decision can be made on case-by-case basis in consultation with SFDPH. See AFL 20-74 and PIN 21-12-ASC for more information, but adjust durations of isolation or quarantine per LTC facility Isolation and Quarantine Table above. **Residents who are new admissions or re-admissions should be managed according to CDC guidance, AFL 21-20, PIN 21-17.2-ASC, and PIN 21-12-ASC.**

Transfer of patients with COVID-19 to LTC facilities

- Per AFL 20-33, AFL 20-87, AFL 21-20, and PIN 20-38, patients with COVID-19 may be transferred to LTC facilities if they are clinically stable, even if they still require isolation/transmission-based precautions, as long as facilities can reasonably accommodate the resident. All new admissions or interfacility transfers diagnosed with COVID-19 must have the approval from SFDPH.
- For discharge approvals and/or questions, email COVID.Outbreak@sfdph.org. A checklist for a LTC Facility to accept a resident with suspected or known COVID-19 is available.

Visitation, communal dining, and activities

Socialization and meaningful connection are important to mental and physical health, especially among LTC facility residents; visitation guidance is rapidly shifting for LTC facilities. Facilities should continue to offer multiple ways to connect with loved ones including **outdoors** when safety and security allow, and virtually to maximize visitation options.

Visitation

LTC Facilities must follow AFL 22-07, and PIN 22-07-ASC.

Visitor vaccination status and testing:

- Although it is not a State or local mandate for residents to be up-to-date on vaccination (instead of fully vaccinated)—it is highly recommended in order to provide the strongest health protections for residents in these settings. Therefore "up-to-date" replaces "fully-vaccinated" in guidance for LTCF residents and staff.
- LTC Facilities must verify visitors are fully vaccinated or have provided evidence of a negative SARS-CoV-2 test within one day of visitation for antigen tests, and within two days of visitation for PCR tests for indoor visitation.
- Any molecular or antigen test used must either have Emergency Use Authorization by the U.S. Food and Drug Administration or be operating per the Laboratory Developed Test requirements by the U.S. Centers for Medicare and Medicaid Services. SNFs can offer onsite point-of-care testing of visitors (either performed by facility staff or observed self-testing) but are not required to. RCF visitors may use observed antigen tests per PIN 22-10-ASC.
- Visitors who are unvaccinated or incompletely vaccinated or are unable to show a negative SARS-CoV-2 test may only have an outdoor visit.
- For visitors who visit for multiple consecutive days, proof of negative test is only required every third day (e.g., on days one, four, and seven).
- Visitors who have tested positive within the last 90 days and completed their isolation may show proof of infection instead of testing.

All visitors entering the facility, regardless of their vaccination status, must:

- Be screened for fever and COVID-19 symptoms and/or exposure within the prior 14 days to another person with COVID-19.
- Be asked to reschedule their visit if they have COVID-19 symptoms, have been in close contact with a confirmed positive case, or are under isolation or quarantine. Per guidance, even if visitors have met community level criteria for discontinuing isolation or quarantine, **they should**

not visit in a healthcare or congregate setting until they have met criteria that would be used to discontinue isolation or quarantine of unvaccinated residents in that setting.

- Wear a well-fitting face mask (N95, KF94, KN95 or surgical masks are preferred over cloth face coverings) and perform hand hygiene upon entry and in all common areas in the facility.
- **Visitors who are unable to adhere** to the core principles of COVID-19 infection prevention **or who have tested positive for COVID-19 should not be permitted** to visit or should be asked to leave. See AFL 22-07**, and** PIN 22-07-ASC for alternative visitation options.

Exceptions:

- **Visitors who are visiting for essential visitation needs, including visiting a resident in critical condition** when death may be imminent, are exempt from the vaccination and testing requirements, however, must comply with all infection control and prevention requirements applicable for indoor visits.
- If the resident is unable to leave their room to visit outdoors, visitation may take place indoors, even for visitors who cannot provide proof of vaccination or a negative test. Visits cannot take place in common areas, in room if the resident's roommate is present, resident and visitor must wear a well-fitted mask (N95, KF94, KN95, or surgical mask is preferred over cloth face coverings) at all times and distance.

Outdoor visitation

- Outdoor visits pose a **lower risk** of transmission and should be offered unless the resident cannot leave the facility, or outdoor visitation is not possible.
- Outdoor visits between residents and all visitors who are fully vaccinated must be conducted with face masks and may include physical contact (e.g., hugs, holding hands.) Visits between residents or visitors that are unvaccinated or incompletely vaccinated should be conducted with well-fitting face masks during the visit.

Indoor visitation

- During large indoor communal-space visits between residents and visitors who are all **up to date** on vaccination, both resident and visitor must always wear a well-**fitting face mask unless actively eating or drinking;** these visits may be conducted without physical distancing and include physical contact.

Communal dining

Facilities should refer to AFL 22-07 and PIN 22-07-ASC or any versions that supersede them. If there are differing requirements between the most current CDC, CDPH, CDSS, CDDS, and local public health department guidance or health orders, licensees should follow the strictest requirements. The following highlights key messages on communal dining:

- RCF residents and visitors:
    - RCF residents not in isolation or quarantine may participate in communal dining and dine with their visitors, **regardless of the vaccination status of the resident,** if the visitor is up-to-date on vaccination AND provides proof of a negative COVID-19 test; the test must be from within one day prior to visitation if antigen, or within two days prior if PCR.
- SNF residents and visitors:

- **Residents** who are up-to-date on vaccination and are not in isolation or quarantine may eat in the same room without physical distancing, and with their **visitors who are up-to-date on vaccination.** Visitors and residents must wear a well-fitting face mask except while actively eating or drinking**.**

If any residents who are NOT up-to-date on vaccination are dining in a communal area, all residents should use source control when not eating and unvaccinated residents should continue to remain at least 6 feet from others. Consider outdoor options whenever safety and security allow.

Communal activities

Per AFL 22-07 and PIN 22-07-ASC, residents who are up-to-date on vaccination and not in isolation or quarantine may participate in group activities in stable cohorts without face masks or physical distancing**.**

If any residents who are NOT up-to-date on vaccination are present, then all participants in the activity should wear a well-fitting face mask and unvaccinated residents should continue to physically distance from others. Consider outdoor options whenever safety and security allow.

Resources

San Francisco Department of Public Health (SFDPH)

- https://sfdph.org/healthorder
- https://sfdph.org/directives
- https://sfdph.org/iandq
- Facility & care worker requirements: https://www.sfdph.org/dph/alerts/files/C19-07-State-and-Local-Mandates-Chart.pdf

California Department of Public Health (CDPH)

- All Facilities Letters (AFLs): https://www.cdph.ca.gov/Programs/CHCQ/LCP/Pages/LNCAFL.aspx

California Department of Social Services (CDSS)

- Provider Information Notices (PINs) for Adult and Senior Care (ASC) Program: https://www.cdss.ca.gov/inforesources/community-care-licensing/policy/provider-information-notices/adult-senior-care

Centers for Disease Control and Prevention (CDC)

- Interim Infection Prevention and Control Recommendations to Prevent SARS-CoV-2 Spread in Nursing Homes https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html
- Updated Healthcare Infection Prevention and Control Recommendations in Response to COVID-19 Vaccination https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-after-vaccination.html#WorkRestriction
- Return to work criteria for healthcare personnel (updated guidance) https://www.cdc.gov/coronavirus/2019-ncov/hcp/return-to-work.html

Centers for Medicare & Medicaid Services (CMS)

- COVID-19 LTCF guidance revised: https://www.cms.gov/files/document/qso-20-39-nh-revised.pdf